KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Division of Health

Bureau for Children, Youth and Families

Note: Program Discontinued 6-30-09

Senator Stan Clark

Pregnancy Maintenance Initiative

Grant Program

Application and Program Procedures

May 26, 2005

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SECTION ONE
GENERAL INFORMATION

A. INTRODUCTION

The purpose of the Application and Program Procedures is to assure consistency and uniformity in the implementation of the Senator Stan Clark Pregnancy Maintenance Initiative (PMI) grant program. This document defines program and service requirements, reporting requirements, contractual requirements, and competitive application and award processes. State general funds to support this initiative are appropriated for the state fiscal year to the Kansas Department of Health and Environment (KDHE).

B. BACKGROUND INFORMATION

This program was first proposed in the 1999 legislative session and funded at $300,000 for SFY 2000. Four local agencies received grants through a competitive application process. Subsequently, the initiative was eliminated in the Fall, 2002 allotments. The legislature reinstated the program with no appropriation in the 2003 session, and in the 2004 session although vetoed. The 2005 Kansas legislature reinstated the program for SFY 06 with an appropriation of $300,000 state funds and dedicated the program to the memory of Senator Stan Clark.

The purpose of the Senator Stan Clark PMI program is to award grants to non-for-profit organizations for services to enable pregnant women to carry their pregnancies to term. Key points of the Senator Stan Clark PMI statute are as follows: (a) subject to available appropriations, KDHE creates, develops and administers the PMI initiative; (b) annual awards to not-for-profit organizations using guidelines and criteria prescribed through rules and regulations; (c) a dollar for dollar match by participating organizations; (d) services may include an array of social services with (1) no individual denied services when unable to pay, and (2) inclusion of adoption services, education or information; (e) organizations performing, promoting, referring for or educating in favor of abortion are ineligible for grants; (f) no funds can be used for political purposes; (g) KDHE submits an annual report to the legislature on results and outcomes; (h) specifies use of standard reporting forms to collect information on number of women served, percent of funds used for prenatal and for post-birth services, and number of women choosing adoption. Funds appropriated for the PMI initiative shall be contracted to successful applicants for provision of PMI services.

C. INITIATIVE DESCRIPTION

1. Services for women to help them carry their pregnancies to term.
2. Services include an array of social services relating to pregnancy maintenance.
3. Services are provided during the pregnancy and/or for up to one year after the birth based on individual client needs and attainment of client-set goals.
4. Individuals who are unable to pay for PMI services shall not be denied access to such services.

D. FUNDING, MATCH AND GRANT PERIOD

1. An annual appropriation of state general funds is for grants to local agencies.
2. The grant period conforms to the state fiscal year: July 1 through June 30 of the following year.
3. The number of grants awarded in any one state fiscal year will be contingent upon the amount of funding available.
4. The grants shall be awarded annually on a competitive basis.
5. Pending the availability of legislative appropriations, highest priority is to continue funding of local agencies that demonstrate progress toward specific objectives.
6. There is a required match of one dollar for each state dollar awarded. Local matching dollars must be used solely for PMI activities enumerated under Section Two of this document. The match may be from the applicant's local budget, private or foundation dollars, or in-kind support (e.g. volunteer timesheets, documented donated office space).
7. Grant funds may not be used to engage in political activities.

E. ELIGIBLE APPLICANTS

1. This is a competitive grant application process. It is the intent of KDHE to award contracts so that services are available in all areas of the State.
2. Organizations with documented experience and capacity to provide PMI services as described within this document are invited to submit applications.
3. Not eligible to apply:
   a. Organizations without not-for-profit status.
   b. Organizations that perform, promote, refer for, or educate in favor of abortion.
4. Organizations that submit an approved application for funding utilizing Application for Grant form (Appendix A), Detailed Budget for Grant Funds (Appendix B), and Narrative Plan for providing services including the numbers of women to be served and community service plans.
5. Contractual provisions of the State and KDHE (Appendix C) will apply to all Grantees.

SECTION TWO
PROGRAM REQUIREMENTS

A. GENERAL REQUIREMENTS

1. PMI services, as described within this document, shall be provided for pregnant women.
2. Services may be provided for up to one year post delivery based on individual client needs and attainment of client-set goals.
3. Grantee will have on file written protocols that clearly outline how the local pregnancy maintenance services are to be implemented, to include, at a minimum: days of week/hours services are available; client confidentiality; eligibility criteria; staff responsibilities, qualifications and credentials; process for client intake and needs assessment; goal planning, and follow-up procedures; referral criteria and feedback process; system for scheduling client appointments and follow-up of clients; plan and method for promoting services throughout the service area and determining need for service in the target area; outreach methods; and, procedure for evaluation of client satisfaction with services. These protocols must be readily accessible to KDHE staff and service providers.
4. Grantee will have on file signed agreements between the Grantee and service providers who will accept referrals for services not provided directly by the Grantee. These agreements will state the purpose of the agreement and the responsibilities of the Grantee, responsibilities of the off-site service provider, and mutual responsibilities including review of the agreement.
5. Grantee will have in place formal procedures for determining client satisfaction with services and written documentation of results with subsequent actions.
6. Grantee will utilize, at a minimum, the following PMI forms: Demographic & Service Summary, and Pregnancy Outcome Data (Appendices D and E); Affidavit of Expenditures (Appendix F).
7. Grantees are advised to use the following forms or comparable forms to document services: Client Intake and Needs Assessment, Client Goal Plan, and Client Goal Tracking, Client Satisfaction Survey and Summary (Appendices G-J).
8. Grantee will participate in on-site visits by KDHE staff in which services, protocols, client records, and fiscal records will be reviewed.
9. As a condition of accepting grant funds, the Grantee will be required to input records data in development of the annual report to the State Legislature.

B. SPECIFIC REQUIREMENTS

1. PMI services are based on a case management model that incorporates an integrated, collaborative, and multi-disciplinary provider approach for the provision of a continuum of care during the pregnancy and for one-year post delivery. This approach minimizes duplication or fragmentation of services. The service model should promote public/private partnerships to facilitate the availability and ready access to affordable and appropriate care, thus improving the potential for a positive pregnancy outcome for the childbearing woman and infant.

2. Case management services are provided by the Grantee and serve as the entry point into the system. The case manager will:
   a. Complete a strengths and needs assessment for each client through the use intake and assessment forms.
   b. Develop collaboratively with the client, a measurable goal plan through the use of a client goal plan.
   c. Document, in collaboration with the client, attainment of goals, with modifications of the goals as necessary, through the use of a client goal tracking form.
   d. Initiate and document referrals to providers or services not provided by the Grantee, based on the client needs and goal plan.
   e. Obtain written client specific feedback from providers or services who receive referrals.

3. Funds received by the Grantee are to be utilized for case management and other services provided by the Grantee or by others. Grant funds for the following services are to be utilized after all other payment sources, including, but not limited to, insurance coverage, special sliding fee and discount options and/or government assistance programs, have been exhausted. Payment from sources other than PMI funds are documented in the individual client's file.
   a. ***Prenatal medical care***: Access to routine prenatal medical care by physicians, advanced registered nurse practitioners (includes certified nurse midwives). Includes routine prenatal laboratory tests and diagnostic ultrasound when the primary diagnosis supports the medical necessity for an OB sonogram. (Excludes ultrasound tests solely for the purpose of determining the sex of the fetus.) Does not include in-patient care during the pregnancy or at the time of delivery for the mother or for the infant.

   b. ***Medical care (non-pregnancy related) for the woman and infant (up to one year of age):*** Services by a licensed medical provider (includes physicians and advanced registered nurse practitioners) for the routine health maintenance, prevention or treatment of non-pregnancy related illness, or injury.
   c. ***Housing:*** Support for housing, excluding the client's usual residence.
   d. ***Education:*** Activities that will facilitate the client's ability to advance toward a high school diploma, GED, or vocational training during the time the client is participating in the PMI case management services.
   e. ***Promotion of Paternal Involvement and Responsibility:*** Opportunities that will support interaction between the mother and the infant's father as appropriate; interaction by the infant's father; assistance with the legal process for the establishment of paternity; parenting education.
   f. ***Adoption Counseling and Referrals:*** Provision by the Grantee or facilitation of access to services that will provide accurate information regarding the adoption process.

g. ***Drug and Alcohol Assessment and Treatment*** Assistance by the case manager to obtain substance use screening, assessment and treatment by licensed or certified substance abuse programs/providers

h. ***Domestic Abuse Protection:*** Assistance by the case manager to any service or facility that will assure physical and emotional security and safety for the client, fetus, infant and other children.

i. ***Child Care:*** Assistance to obtain child care while the client is participating in the pregnancy maintenance program and during one year post-delivery when the parent or guardian is absent, excluding in-home services.

j. ***Parenting Education/Support:*** Provision of parenting education to promote infant development and emotional support during the first year of the infant's life.

k. ***Transportation:*** Provision of transportation, when not otherwise available in the service area, for the client and child(ren) to access program services.

4. Case Manager Qualifications:

a. Discipline and Education: The case manager shall be a registered nurse or licensed social worker.

b. Professional Experience: The case manager shall have a minimum of two years experience working with pregnant women, beyond basic professional education. Preferred, but not required, the case manager shall have experience working with pregnant women in an out-patient clinic, office, or public health prenatal program.

c. Community Experience: The case manager should be knowledgeable about resources in the service area; experienced in establishing and maintaining communication, linkages and agreements with community partners; verbalize methods professionally implemented to assure the availability of, and access to services and utilization of resources required by the PMI.

SECTION THREE
REPORTING REQUIREMENTS

A. FISCAL AND PROGRAM NARRATIVE REPORT SUBMISSION

All fiscal and narrative reports are to be mailed to the designated contracts office at the KDHE.

B. FISCAL REPORTS

Grantee will submit to KDHE an "Affidavit of Expenditures" to reflect expenditures for the following periods of time: July 1 through December 31 (due January 15); January 1 through March 31 (due April 15); and April 1 through June 30 (due July 15). Expenses are itemized as they relate to the budget that will be appended to the grant contract. Grantee will utilize the KDHE "Affidavit of Expenditures" form (Appendix F) to report grant and local matching funds expended for each budget category.

C. PROGRAM NARRATIVE

1. Grantee will submit to KDHE two program narratives during the contract year: a report for the first 6 months covering July 1 - Dec 31 which is due Jan 15; and a report covering the second 6 months of Jan 1 - June 30 which is due July 15. The reports will include the following information for the time period covered by the report:
    a. Community outreach activities including use of media to inform the community about the availability of services.
    b. The number of women who utilized the services and the services they received.
    c. Summary of Client Satisfaction Responses received during the report period.
    d. Results of quality assurance activities and description of modifications in local service plan.
    e. Special service needs identified during the reporting period and methods identified to meet those needs.
    f. Local achievements; staff changes; pertinent client case examples; changes or additions to local PMI policies/procedures.
    g. Percentage of funds used for pre-natal services and the percentage used for post-birth services.
    h. Number of women choosing adoption.
2. Any print materials developed for clients by the Grantee should be appended to the mid-year narrative and end of year reports.
3. Program narrative header should be as follows:
    Pregnancy Maintenance Initiative Narrative Report
    Report Period: _____
    Grantee Name: _____

D. SERVICE & CLIENT DATA REPORTS

1. The following service and client demographic information are to be submitted on the Client Demographics and Perinatal Outcome forms (Appendices D & E). These forms are appended to the program narrative that is to be submitted for the reporting periods of July 1 - December 31 (due January 15 of the following calendar year) and January 1 - June 30 (due July 15 of the same calendar year).
   a. Number of users receiving PMI services. A "user" is defined as a client who is seen one or more times and who may receive one or more of the PMI services. A user is to be counted only one time during the contract year.
   b. Number of users by race (White, Black or African American, American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other) and ethnicity (Hispanic or Non-Hispanic); age (under 15, 15-17, 18-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-54, 55 or older); county of residence, highest level of education attained; employment status, poverty level based on the U.S. DHHS federal poverty guidelines; health coverage, and county of residence.
   c. Perinatal Outcomes: Number of clients who delivered during the reporting period; Number of these clients that had positive maternal outcomes (e.g. term delivery, absence of complications and did not require an extended hospitalization, > 3-5 days); Number of live births; Number and percent of the live births weighing greater than or equal to 2500 grams (5.5 pounds); Number and percent of the live births weighing 1500 - 2499 grams (3.3 to 5.4 pounds - low birthweight); Number and percent of the live births weighing less than 1500 grams (less than 3.3 pounds - very low birthweight); Number and percent of fetal deaths/stillbirths; Number of infants born to program clients who subsequently died during the first year of life (infant deaths).

SECTION FOUR
CONTRACTUAL REQUIREMENTS

A. CONTRACTUAL PROVISIONS

The PMI grantee will comply with contractual requirements of the State of Kansas and the KDHE.

SECTION FIVE
APPLICATION AND REVIEW PROCESS

A. APPLICATION SUBMISSION

1. The KDHE will conduct an annual competitive application and review process with public notice of the process in the Kansas Register and such other sites as appropriate to notify all potential applicants.
2. Applicants must respond by submitting all information requested in the format prescribed by the KDHE. Failure to submit all information requested shall be deemed sufficient cause for disqualification of the application from further consideration.
3. Designated staff from the KDHE will provide technical assistance regarding the application process to potential applicants upon request.

B. APPLICATION REVIEW

5. Applications will be reviewed by a panel of individuals from KDHE and other State agencies and others with specific expertise in prenatal services and systems.
6. The application will be reviewed for conformance to the Application and Program Procedures.
7. Reviewers will conduct a comparative assessment of the strengths and deficiencies of the applications, applicant experience, qualifications of personnel, adequacy of service plan, budget, and budget justification.
4. KDHE reserves the right to consider historic information and fact, whether gained from the local agency's application, question and answer conferences, references, or any other source, in the application review process.

C. GRANT AWARD NOTIFICATION

Any grant award announcement or contract offer will be in writing from KDHE.

2. KDHE reserves the right to allocate funds based on need in accordance with data and information available to the KDHE.
3. Applications are reviewed on a competitive basis, and, as a result, all applicants may not receive an award. KDHE reserves the right to accept any application, to reject any or all applications, in full or in part, and to waive irregularities and/or formalities as deemed appropriate.

APPENDIX A

State of Kansas
Department of Health & Environment

To be completed by State Office
Date Received: _____

1000 SW Jackson, Ste 220
Topeka, KS 66612-1274
(785) 296-1306

Grant Period:
July 1, _____ - June 30, _____

APPLICATION FOR GRANT

_____
Applicant (Name of Agency)

_____
Street Address/Courthouse

_____
City Zip Code

_____
Name of Organization Administrator/Director

_____
Telephone: Area Code-Number

_____
Fiscal Officer

_____
Telephone: if different from Applicant Agency

_____
Type of Organization - (County, City-County, Voluntary, Multi-County, Non-Profit)

FEIN #_____

_____
Where will program be conducted (counties)?

_____
President/Chairman Agency Board of Directors

Date _____

Application Checklist:

___ Grant Budget (grant funds + local match)

___ Budget Narrative

___ Application Narrative & Supporting Documents

GRANT FUNDS REQUESTED

Pregnancy Maintenance Initiative $_____

TOTAL FUNDS REQUESTED $_____

_____
Administrator/Director

Date _____

Instructions for completing **APPLICATION FOR GRANT FORM**

One completed form is required as the cover sheet for each Local Agency application. Check the items submitted with the application. Completed **PROGRAM REQUEST FORMS** and **DETAILED BUDGET FORMS** are attached to this cover sheet.

The section for "Comments" should be used to explain or clarify your funding requests.

Signatures. This form must be signed by both the President/Chairman of Local Agency Board and the Administrator/Director.

Detailed Budget for Grant Funds
1, _____-June 30, _____

1. LOCAL AGENCY: _____ July
2. PROGRAM:

	FTE Salary for Grant Period	FTE % Time Worked	Local Applicant's Share	Requested from Grant	TOTAL
3. Personnel (Type of Position) FICA (7.65%) Retirement (__)					
Category Total					
4. Travel					
Category Total					
5. Supplies					
Category Total					
6. Capital Equipment (**ITEMIZE**)					
Category Total					
7. Other (**ITEMIZE**)					
Category Total					
8. **GRAND TOTAL**					

SEE COMPLETION INSTRUCTIONS ON THE BACK.

KDHE USE ONLY:
Audited By:

COMPLETION INSTRUCTIONS FOR DETAILED BUDGET FOR GRANT FUNDS

The budget is the plan for necessary financing to achieve the process and outcome objectives. The plan for financing should receive serious consideration so that few changes will occur to budget line items during the administration of the grant. If for some reason, during the grant award period a variance of more than 10% should occur, an amended budget should be filed with the Accounting Services, Attn: Aid-to-Local, 1000 SW Jackson St., Ste 570, Topeka, KS 66611-1274. If you have questions, please contact Kevin Shaughnessy at (785) 296-1507.

1. PRINT OR TYPE THE NAME OF THE ORGANIZATION RECEIVING THE GRANT AWARD.

2. PRINT OR TYPE THE TITLE OF THE GRANT AWARD **EXACTLY** AS IT APPEARS ON THE CONTRACT/ATTACHMENT.

3. Each employee position should be listed separately with the position title and name of the employee (or "VACANT" if not currently filled). The "Salary for Grant Period" and "% Time Worked" should be based on full time equivalency (FTE). The percentage of time worked together with the salary should be shown in the appropriate columns.

   . FTE Salary for Grant Period should be the ANNUAL Salary. (If an hourly rate is paid then show the hourly rate TIMES the number of hours.)

   . FTE % Time Worked should be the percentage of time that position spends on the program.

   . Use the following formulas:

      . FTE Salary for Grant Period X FTE % Time Worked = Total
      . Local Applicant's Share + Requested from Grant = Total

   . Retirement and F.I.C.A. should be shown as separate items and are based on the total salary(ies) for the program. Please indicate the percentage rate used for retirement, insurance, etc., as each Local Agency differs in these areas. Please identify the salaries used in calculating retirement, insurance, etc.

4. Include only meals, lodging, transportation and other miscellaneous expenses. Do not include salary of employee during travel.

5. Expendable supplies include all types of supplies. Do not include capital items.

6. Capital Equipment is defined as items costing $5,000 or more. If possible, either avoid budgeting for capital equipment or show it financed in the Local Applicant's share column. Capital Equipment purchased with State or Federal funds (except State Formula funds or other special grant funds) must be carried on the equipment inventory of KDHE, and KDHE and the individual local health agencies must annually account for the equipment. Each capital item to be purchased with grant funds should be listed separately.

7. Expenditure items in the "Other" category would include contractual services such as consultants, rental of equipment, etc. Each projected expenditure item in the "Other" category should be listed separately.

   INDIRECT COST AND CONTRIBUTIONS ARE ACCEPTABLE AS PART OF THE LOCAL MATCH ONLY, AFTER THE AGENCY HAS SUBMITTED AN ANNUAL INDIRECT COST PROPOSAL WHICH MEETS KDHE REQUIREMENTS. Items included in the indirect cost computation cannot be included as direct cost items.

8. Add lines 3 through 7 under each column for the Grant Total. NOTE: The amounts in Local Applicant's Share column plus the Requested from Grant Column should equal the total in the Total column.

ATTACH ADDITIONAL SHEET(S) AS NECESSARY.

State of Kansas
Department of Administration
DA-146a (Rev. 6-96)

CONTRACTUAL PROVISIONS ATTACHMENT

Important: This form contains mandatory contract provisions and must be attached to or incorporated in all copies of any contractual agreement. If it is attached to the vendor/contractor's standard contract form, then that form must be altered to contain the following provision:

"The Provisions found in Contractual Provisions Attachment (Form DA-146a, Rev. 6-96), which is attached hereto, are hereby incorporated in this contract and made a part thereof."

The parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being the _____ day of _____, 19___.

1. TERMS HEREIN CONTROLLING PROVISIONS
It is expressly agreed that the terms of each and every provision in this attachment shall prevail and control over the terms of any other conflicting provision in any other document relating to and a part of the contract in which this attachment is incorporated.

2. AGREEMENT WITH KANSAS LAW
All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Kansas.

3. TERMINATION DUE TO LACK OF FUNDING APPROPRIATION
If, in the judgment of the Director of Accounts and Reports, Department of Administration, sufficient funds are not appropriated to continue the function performed in this agreement and for the payment of the charges hereunder, State may terminate this agreement at the end of its current fiscal year. State agrees to give written notice of termination to contractor at least 30 days prior to the end of its current fiscal year, and shall give such notice for a greater period prior to the end of such fiscal year as may be provided in this contract, except that such notice shall not be required prior to 90 days before the end of such fiscal year. Contractor shall have the right, at the end of such fiscal year, to take possession of any equipment provided State under the contract. State will pay to the contractor all regular contractual payments incurred through the end of such fiscal year, plus contractual charges incidental to the return of any such equipment. Upon termination of the agreement by State, title to any such equipment shall revert to contractor at the end of State's current fiscal year. The termination of the contract pursuant to this paragraph shall not cause any penalty to be charged to the agency or the contractor.

4. DISCLAIMER OF LIABILITY
Neither the State of Kansas nor any agency thereof shall hold harmless or indemnify any contractor beyond that liability incurred under the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.).

5. ANTI-DISCRIMINATION CLAUSE
The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-111 et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101 et seq.) (ADA) and to not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, or age in the admission or access to, or treatment or employment in, its programs or activities; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of contract and the contract may be canceled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration; (f) if it is determined that the contractor has violated applicable provisions of ADA, such violation shall constitute a breach of contract and the contract may be canceled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration.

Parties to this contract understand that the provisions of this paragraph number 5 (with the exception of those provisions relating to the ADA) are not applicable to a contractor who employs fewer than four employees during the term of such contract or whose contracts with the contracting state agency cumulatively total $5,000 or less during the fiscal year of such agency.

6. ACCEPTANCE OF CONTRACT

This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.

7. ARBITRATION, DAMAGES, WARRANTIES

Notwithstanding any language to the contrary, no interpretation shall be allowed to find the State or any agency thereof has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, the State of Kansas shall not agree to pay attorney fees and late payment charges beyond those available under the Kansas Prompt Payment Act (K.S.A. 75-6403), and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

8. REPRESENTATIVE'S AUTHORITY TO CONTRACT

By signing this contract, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this contract on behalf of the contractor and that the contract agrees to be bound by the provisions thereof.

9. RESPONSIBILITY FOR TAXES

The State of Kansas shall not be responsible for, nor indemnify a contractor for, any federal, state or local taxes which may be imposed or levied upon the subject matter of this contract.

10. INSURANCE

The State of Kansas shall not be required to purchase, any insurance against loss or damage to any personal property to which this contract relates, nor shall this contract require the State to establish a "self-insurance" fund to protect against any such loss of damage. Subject to the provisions of the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.), the vendor or lessor shall bear the risk of any loss or damage to any personal property in which vendor or lessor holds title.

11. INFORMATION

No provision of this contract shall be construed as limiting the Legislative Division of Post Audit from having access to information pursuant to K.S.A. 46-1101 et seq.

Appendix D

PREGNANCY MAINTENANCE INITIATIVE
CLIENT DEMOGRAPHIC SUMMARY
(NEW CLIENTS ENROLLED DURING REPORTING PERIOD)

_____ _____
(LOCAL AGENCY NAME) (*REPORTING PERIOD)*

A. RACE, AGE, AND ETHNICITY

RACE	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45-54	55+
White										
Black or African American										
American Indian/Alaskan Native										
Asian										
Native Hawaiian/Pacific Islander										
ETHNICITY	**<15**	**15-17**	**18-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-54**	**55+**
Hispanic										
Non-Hispanic										

B. HIGHEST LEVEL OF EDUCATION OBTAINED AT TIME OF ADMISSION

NUMBER OF CLIENTS	< 12 YEARS	HIGH SCHOOL DIPLOMA/GED	< FOUR YRS COLLEGE	COLLEGE DEGREE	VO-TECH

C. EMPLOYMENT STATUS AT TIME OF ADMISSION

NUMBER OF CLIENTS	UNEMPLOYED	EMPLOYED FULL TIME	EMPLOYED PART-TIME

D. POVERTY LEVEL (Based on Federal Poverty Standards)

NUMBER OF CLIENTS	< 50%	51 - 100%	101 - 150%	151% - 185%	186% - 200%	> 200%

E. HEALTH COVERAGE AT TIME OF ADMISSION

NUMBER OF CLIENTS	SELF - PAY	PRIVATE INSURANCE	MEDICAID	MEDICAID AND PRIVATE INSURANCE

F. MARITAL STATUS

NUMBER OF CLIENTS	SINGLE	MARRIED	SEPARATE	DIVORCED	WIDOWED

G. COUNTY OF RESIDENCE AT TIME OF ADMISSION (USE COUNTY ABBREVIATION)

COUNTY									
NUMBER									

Appendix E

PREGNANCY MAINTENANCE PREGNANCY INITIATIVE
PREGNANCY OUTCOME DATA FOR REPORTING PERIOD

(Attach this form to the program midyear and end of year narrative report.)

_____

(LOCAL AGENCY NAME) (*REPORTING PERIOD)*

A. LIVE BIRTHS/RACE AND ETHNICITY

White	Black or African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Hispanic	Non-Hispanic

B. LIVE BIRTHS/GESTATION LESS THAN 37 WEEKS

White	Black or African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Hispanic	Non-Hispanic

C. LIVE BIRTHS/BIRTHWEIGHT

BIRTHWEIGHT	White	Black or African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Hispanic	Non-Hispanic
> 1500 GMS 1500-2400 GMS							

D. FETAL DEATHS/STILLBIRTHS (Greater than 350 Gms)

White	Black or African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Hispanic	Non-Hispanic

E. INFANT DEATHS

INFANT AGE	White	Black or African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Hispanic	Non-Hispanic
LESS THAN 7 DAYS							
7 TO 27 DAYS							
28 TO 364 DAYS							

F. ADOPTIONS/MATERNAL AGE/RACE AND ETHNICITY

RACE	*<15*	*15-17*	*18-19*	*20-24*	*25-29*	*30-34*	*35-39*	*40-44*	*45-54*	*55+*
White										
Black or African American										
American Indian/Alaskan Native										
Asian										
Native Hawaiian/Pacific Islander										
ETHNICITY	*<15*	*15-17*	*18-19*	*20-24*	*25-29*	*30-34*	*35-39*	*40-44*	*45-54*	*55+*
Hispanic										
Non-Hispanic										

An electronic copy of this form is available at "www.kdhe.state.ks.us/doc_lib/index.html"

APPENDIX F

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
CATEGORICAL PROGRAMS AFFIDAVIT OF EXPENDITURES

1. GRANTEE NAME: _____

Phone: ( ) _____

2. REPORT PERIOD: _____

3. GRANT TITLE: _____

FOR INSTRUCTIONS:
See cell comments
(indicated by red tabs)

EXPENDITURE CLASSIFICATION	LOCAL MATCH AMOUNT	GRANT AMOUNT	TOTAL AMOUNT
4. SALARIES (Including fringe benefits)			
Sub-total Salaries			
5. TRAVEL			
Sub-total Travel			
6. SUPPLIES			
Sub-total Supplies			
7. CAPITAL EQUIPMENT (List each item, make, model, serial #, include copy of invoice)*			
Sub-total Capital Equipment			
8. OTHER (List each item/cost)			
Sub-total Other			
9. AFFIDAVIT TOTAL (Add lines 4 - 8)			

By (electronic) submission, the local agency administrator below certifies that this report is in agreement with the agency official accounting records and that individual employee time reports are maintained documenting time charged to this program.

10. ADMINISTRATOR NAME: _____

DATE: 21

KDHE USE ONLY:
AUDITED BY:

PREGNANCY MAINTENANCE INITIATIVE
INTAKE & NEEDS ASSESSMENT

NAME: _____ DATE: _____

COUNTY OF RESIDENCE: _____ BIRTH DATE: _____

Do you consider yourself to be of Hispanic origin? Yes No

RACE (Circle): White Black or African American Am. Indian/Alaska Native Asian

Native Hawaiian/ Other Pacific Islander

PREGNANCY INFORMATION

1. My due date is _____
   Month Day Year

2. I have been pregnant, including this pregnancy, _____ times.

PRENATAL CARE AND OTHER MEDICAL CARE

3. Who will be providing your prenatal care? _____

4. Who is your primary health care provider? _____

5. Who will be the baby's doctor? _____

FEELINGS ABOUT THE PREGNANCY

6. Thinking back to just before you became pregnant did you want to become pregnant at this time?

   - □ Yes
   - □ No
   - □ I don't remember
   - □ No answer

7. List any words that describe your feelings about this pregnancy.

   _____

8. How does the father of the baby feel about you being pregnant?

_____

9. At the present time, I am planning:
   - ☐ to continue the pregnancy
   - ☐ to end the pregnancy
   - ☐ to place the baby up for adoption
   - ☐ unsure what I will do

HOUSING

10. I need assistance to locate housing for myself (and children).
    Yes ☐ No ☐

PATERNAL AND FAMILY SUPPORT/INVOLVEMENT

11. Do you and the baby's father live together?
    Yes ☐ No ☐

12. Do you anticipate that the baby's father will assist you with your financial needs while you are pregnant?
    Yes ☐ No ☐

13. Do you need information about the father's legal responsibilities to provide for the support, educational, medical and other needs of the baby?
    Yes ☐ No ☐

14. I will be receiving help or support from:
    The Baby's Father ☐ My Boy Friend (not the baby's father) ☐
    My parents ☐ Others (explain)_____

FINANCES, TRANSPORTATION AND PERSONAL NEEDS

15. I am concerned about having money for:
    Food ☐ Clothing ☐ Utility Bills ☐ Medical Bills ☐
    Rent ☐ Child Care ☐ Baby Items ☐ Transportation ☐
    Housing ☐ Other, explain _____

16. I need the following baby items:
    Baby Bed ☐ Diapers ☐ Baby Clothes ☐ Baby Blankets ☐
    Bottles/Nipples ☐ Car Seat ☐ Others, explain _____

17. I usually use the following method of transportation:
Drive myself ☐ Taxi ☐ Bus ☐ Family/Friend ☐

18. My current household income per month is $_____.

19. There are currently _____(number) people in my household.

RESOURCES

20. I have the following way to pay for my prenatal medical care:
Private Insurance ☐ Medical Card ☐ Cash Savings ☐

21. I am currently employed.
Yes ☐ Where: _____

No ☐ Why: _____

22. Do you anticipate that your pregnancy will cause you to change jobs or lose your job?
Yes ☐ No ☐

23. I am enrolled in the WIC Program
Yes ☐ No ☐

24. Last grade attended: _____

25. Attending school now?

Yes ☐ Where: _____

No ☐ Why: _____

26. I plan to:
☐ Complete high school
☐ Get a GED
☐ Attend vocational school
☐ Attend college

CHILD CARE

27. I need assistance obtaining child care for my other children.
Yes ☐ No ☐

28. I will need assistance obtaining child care for my newborn.
Yes ☐ No ☐

OTHER

29. Do you have plans for the future? How would these be affected?

_____

30. I have been a victim of abuse (physical, rape, incest, verbal).
Yes ☐ Explain. _____

No ☐

31. Do you drink beer or alcohol or use drugs?
Yes ☐ No ☐

32. Have you ever participated in any counseling regarding your use of beer, alcohol or drugs?
Yes ☐ No ☐

ADDITIONAL INFORMATION

Feel free to add other concerns you have at this time.

_____

_____

_____

_____

_____

_____

Bureau for Children, Youth and Families
Kansas Department of Health & Environment
7/05

PREGNANCY MAINTENANCE INITIATIVE CLIENT GOAL PLANNING

CLIENT NAME: _____CASE MANAGER: _____DATE INITIATED: _____

GOAL CATEGORY	**WHAT IS CURRENTLY HAPPENING?**	**WHAT DO I WANT?**	**WHAT HAVE I DONE IN THE PAST?**
PRENATAL MEDICAL CARE			
MEDICAL CARE (NON-PREG) (CLIENT & INFANT)			
HOUSING			
EDUCATION			
PATERNAL INVOLVEMENT			
ADOPTION GUIDANCE			
DRUG/ALCOHOL ASSESSMENT & TREATMENT			
DOMESTIC ABUSE PROTECTION			

GOAL CATEGORY	WHAT IS CURRENTLY HAPPENING?	WHAT DO I WANT?	WHAT HAVE I DONE IN THE PAST?
CHILD CARE			
PARENTING EDUCATION & SUPPORT			
TRANSPORTATION			

PREGNANCY MAINTENANCE INITIATIVE CLIENT GOAL TRACKING

NOTE: UTILIZE A GOAL TRACKING FORM FOR EACH GOAL

CLIENT NAME: _____ CASE MANAGER: _____

Date Initiated _____
Date(s) Reviewed _____
_____
_____

GOAL CATEGORY: (Circle appropriate category)

Prenatal Medical Care; Medical Care (non-pregnancy); Housing; Education; Paternal Involvement; Adoption Guidance; Drug & Alcohol Assessment/Treatment; Domestic Abuse Protection; Child Care; Parenting Education/Support; Transportation; Other, specify _____

GOAL: _____

I will complete this goal by doing the following	Date Written	Responsible Party	Date to be Completed	Status Toward Achieving Goal	Date Achieved	Comments
1. Client's Initials _____						
2. Client's Initials _____						

I will complete this goal by doing the following	Date Written	Responsible Party	Date to be Completed	Status Toward Achieving Goal	Date Achieved	Comments
3. Client's Initials _____						
4. Client's Initials _____						
5. Client's Initials _____						
6. Client's Initials _____						

Appendix J

Pregnancy Maintenance Initiative Client Satisfaction Survey

1. Agency Name: _____

2. Agency City: _____

3. How did you learn about these services?

Friend/Relative	Brochure from agency listed above
Pregnancy Care Provider	Church
Media (television, radio, newspaper)	Health Department
Adoption Agency	Another agency: _____
School	Other, specify: _____
Hospital	

4. Check the services that you received as a result of your participation with the Pregnancy Maintenance Initiative/Case Management.

Prenatal Medical Care	Adoption Guidance
Medical Care (non-pregnancy related)	Drug/Alcohol Assessment/Treatment
Client Infant	Domestic Abuse Protection
Housing	Child Care
Alternative Education	Parenting Education/Support
Paternal Involvement Support	Transportation

5. How long did you wait for your first visit with the PMI case manager?

less than 1 week	3 weeks
1 week	4 weeks or more
2 weeks	

6. Did you have problems getting to the services (e.g., transportation, appointments conflicted with work schedule or school, child care)?

No Yes Describe the problem: _____

_____

7. Were the days and times for services good for you?

Yes No What days would have been better for you? _____

_____

8. On the average, how long did you have to wait before you were seen by the case manager or other staff at this agency:\?

less than 15 minutes	46 minutes - 1 hour	not applicable
15-30 minutes	1-2 hours	
31-45 minutes	more than 2 hours	

9. During your visits:

Did the case manager carefully listen to you?	Yes	No
Did service providers carefully listen to you?	Yes	No
Do you feel you participated in the goal planning?	Yes	No
Were things explained in a way you could understand?	Yes	No

I you checked "no" to any of the above, please explain:_____

_____

10. Did you feel you were fully informed of:

Available services to continue your pregnancy?	Yes	No
Location of services?	Yes	No
Requirements of services?	Yes	No
Length of services during pregnancy and after?	Yes	No

11. If these services had been unavailable, what would you have done in relation to your pregnancy and other needs?

_____

_____

_____

12. Would you recommend these services to a friend or relative? Yes No

13. How old are you?
under 15 15-17 18-19 20-24 25-29
30-34 35-39 40-44 45-54 55 or older

14. What is your race?
White Black or African American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander Other

15. Do you consider yourself to be of Hispanic origin? Yes No